- MEDICAL CARE PLANS FOR LOW-INCOME FARM FAMILIES -

Developed by the Farm Security Administration

Through the cooperation of state medical associations, the Farm Security Administration has developed plans under which more than 78,000 low-income farm families of 20 states are being helped to obtain medical care at a cost which they can afford.

The Farm Security Administration found it necessary to help provide such medical care in the course of its efforts to rehabilitate more than 600,000 low-income and destitute farm families. Quite aside from any humanitarian purposes it has, as a lending agency, found that a family in good health is a better credit risk than a family in bad health. It has developed plans for medical care because it has found that good health is a necessary part of a family's economic rehabilitation.

The rehabilitation program grew out of the relief problem. More than a million farm families were on relief in 1933. Instead of carrying these families on relief indefinitely, the government seeks to get them back onto their feet, so they can become independent, self-sustaining units in the social and economic life of the community.

Advice is offered by trained agricultural and home management supervisors. Together with the farmers and the farm-wives, they work out plans for the successful operation of the farms and homes. Then loans are made to them by the government so that they can finance the program.

Rehabilitation loans average about $300. They are chiefly used to buy farm equipment, livestock, work animals, fertilizer, seed and the like. They carry interest at five percent and are secured by crop liens and mortgages on livestock. Experience has shown that they are generally repaid.

Only farmers who cannot obtain credit elsewhere are eligible for this kind of help. In most cases they are at the end of their rope. At best, they are poor credit risks from the ordinary business standpoint, and the government's security is dependent upon their success.

Borrowers, in order to repay their loans, must be kept in reasonably good physical condition. They must be able to do ordinary farm work. Provision for medical and dental care is often an important and necessary part of their rehabilitation.

The plans developed by Farm Security Administration to insure medical care for its borrowers are being put into effect only after understandings are reached with local medical societies. As a first step, an agreement is made with the State medical association. This agreement outlines the general principles acceptable to the medical association. Local medical societies in areas where the need seems greatest are then approached for the purpose of working out the details of a medical care plan for borrower families.

The understandings reached with local medical societies provide: (a) that in general the total amount a borrower is to spend for medical care for a given period, usually one year, will be within the ability of the family to pay as determined by the farm plan; (b) that the family shall have free choice of physician; (c) that the funds set aside for compensation of doctors shall be paid at the beginning of the operating period, placed in the hands of a trustee, and may then be pooled into a common fund or earmarked individually by families according to the preference of the local physicians and the local families.

The amount paid for participation varies somewhat in different localities. The usual payment is between $20 and $30 per family per year. Where necessary the Farm Security Administration will increase the size of its loan to a borrower to enable him to participate.

Under the plan in most general use, a certain portion of the funds in the hands of the trustee are set aside at the beginning of each period for hospitalization and emergency needs, including surgery. The remaining fund is then divided into equal monthly allotments for the period covered.

Physicians submit monthly statements for services rendered. If the total bills for a given month exceed the amount available, all bills are proportionately reduced and each physician paid his pro rata share of the month's allotment. If the allotment for the month covered by the statements received is adequate, the bills are paid in full; if a balance remains, it is carried forward to the next month or to the end of the period, and then either used to complete paying bills for months in which funds were not adequate or returned to the family, as directed by the local agreement.

Under an alternative plan, funds in the hands of the trustee are kept separate for each family. The physician chosen agrees to provide medical care for the period for the sum designated; if the bill for medical care rendered is less than the sum set aside, the remainder is refunded to the family. If the amount for medical care exceeds that set aside by a given family, the physician continues attendance during that period without additional compensation. This plan does not provide for hospitalization. Occasionally it is varied to approve pooling of a certain amount from all families to meet hospitalization and emergencies.

Experience with the two plans clearly indicates that for low-income families the first plan is preferable; that is, a plan providing for pooling the individual loans in one general fund. In case of catastrophic illness it is impossible for any family in this income level to pay individually for hospitalization and special medical care without financial ruin

or without destroying the hope of solvency for years to come; yet, it is unfair to ask a physician to handle such a case for a fee which does not cover long and special attention. The pooling of funds serves as a form of voluntary insurance against disaster for the dient and against unreasonable hardship for the doctor.

Both plans, by establishing funds for medical care in advance, encourage a sane acceptance of more preventive medicine. In many areas, local physicians previously have served Farm Security Administration borrowers with little or no compensation. Most families, owing the doctor or unable to pay, have postponed requests for medical care as long as possible, perpetuating minor disabilities or allowing illness to become serious.

Both plans embody a principle worthy of note. Payment for medical care is based on the expected income of the family. The physicians utilize a uniform fee schedule as the basis for their charges, but they agree to accept a pro rata reduction in payment of bills when available funds are insufficient to pay the bills in full. Many physicians were at first distrustful of this deviation from customary procedure, but learning that families embraced under this plan have total net incomes averaging $20 to $300 a year, have realized that they would be unable to pay heavy fees, even in emergency.

Some doubts were expressed about the workability of plans which call for setting aside of sums for medical care when no illness may occur to the family during the year. Experience has cleared up doubts. Most families receive some medical attention, and all seem to feel that the security of the plan is worth the investment.

Fears also were voiced that families would abuse their privilege by requesting unnecessary medical attention. But in most of the coun-

ties where the plans have been understood and adopted this expected abuse has failed to materialize. Often it happens that families will visit their physicians or summon them during the first few weeks more or less for the novelty of the thing -- to see if the plan really works. When they find that the physicians do render service as agreed, they are satisfied. In those rare instances where families are unreasonable in requesting an excess amount of service, the local representative of the Farm Security Administration tries to adjust matters -- generally with success. If this fails the family may be dropped from the program.

Physicians are, in general, pleased with the program. Most of the families aided under the plan have been unable to pay anything in the past, but are now able to pay at least a part, if not the full amount, of the customary fee schedule.

County plans for medical care are in operation in 59 of Arkansas's 75 counties, in 13 counties in Missouri, 12 counties in Mississippi, nine counties in Texas, five counties each in Alabama, Georgia, and Ohio, four counties in Tennessee, three counties in Indiana and Oklahoma, and two counties in Iowa. Agreements have been reached with state medical associations of seven additional states: North and South Dakota, North Carolina, Wisconsin, Utah, New Mexico, Colorado, Virginia and Louisiana. Plans are under way to approach local medical associations in these states.

The financial report of a typical county group health association will demonstrate how the program works. The association, whose report is given below, was sponsored by the Farm Security Administration, but is conducted by local physicians and clients. It is operating in a county in a Southern state that has slightly more than 300 farm families who are clients of the Farm Security Administration. 304 families are members, paying an average of approximately $26.00 per year. The report for the nine month period ending September 30, 1938, follows:

COUNTY HEALTH ASSOCIATION

Financial Report Covering Period January 1, 1938 to Sept. 30, 1938

MEDICAL FUND

	Funds Available	Bills Presented	Bills Paid	Bills Unpaid	Surplus Funds	Proratio monthly Payments
January	$439.85	$427.13	$427.13	$ .00	$12.72	100%
February	439.85	671.03	439.85	231.18	.00	66%
March	439.85	516.59	439.85	76.74	.00	85%
April	439.85	649.91	439.85	210.06	.00	68%
May	439.85	492.40	439.85	52.55	.00	89%
June	439.85	599.23	439.85	159.38	.00	74%
July	439.85	825.30	439.85	385.45	.00	53%
August	439.85	612.97	439.85	173.12	.00	72%
September	439.85	521.88	439.85	82.03	.00	84%
October	439.85					
November	439.85					
December	439.85					
TOTAL	$5,278.20	$5,316.44	$3,945.93	$1,370.51	$12.72	74%

HOSPITAL FUND

	Funds Available	Bills Presented	Bills Paid	Bills Unpaid	Surplus Funds	Proratio monthly Payment
January	$219.92	$10.00	$ 10.00	$ .00	$209.92	100%
February	219.92	251.00	219.92	31.08	.00	88%
March	219.92	79.00	79.00	.00	140.92	100%
April	219.92	296.00	219.92	76.08	.00	74%
May	219.92	188.50	188.50	.00	31.42	100%
June	219.92	327.50	219.92	107.58	.00	67%
July	219.93	192.50	192.50	.00	27.43	100%
August	219.93	224.50	219.93	4.57	.00	98%
September	219.93	200.00	200.00	.00	19.93	100%
October	219.93					
November	219.93					
December	219.93					
TOTAL	$2,639.10	$1,769.00	$1,549.69	$219.31	$429.62	88%

The following services were covered by the expenditures from the Hospital Fund:

Tonsillectomy	22	Circumcision	1	Special Laboratory	2
Appendectomy	8	Carbuncle	1	Operating Room	36
Cystectomy	2	Hysterectomy	1	Biopsy	1
Abcesses	2	Breast Amputation	1	Laparotomy	1
Empyema	1	Days Hospitalization	203	Dysmenorrhea	1
Fistular	1	Anesthetics	36	Infections	1
Caesarean	1	X-rays	3		

In North and South Dakota, a somewhat different approach has been required because of the large number of families in need of help as a result of repeated droughts. In those two states, state-wide programs were inaugurated on November 1, 1938, for all families receiving help, or which have received help in the past, from the Farm Security Administration.

About 40,000 farm families, or half of the farming population of the state, are eligible in South Dakota. The program contemplates membership by at least 20,000 of these families.

In North Dakota, about 37,000 families are eligible. About 25,000 of them were already participating in a previous plan, and carried over into the new program.

Participating families in these two states become members of the North Dakota Farmers Mutual Aid Corporation or the South Dakota Farmers Aid Corporation upon the payment in advance of a fee at the rate of $2.00 per month, per family. No family is accepted for a period of less than six months.

Families without this money receive loans from the Farm Security Administration to permit them to become members of the Corporation. The funds received from these low-income farm families are placed in a central fund. The money is used in paying for emergency medical care, emergency dental care, emergency hospitalization, for the prescribed drugs and the necessary medical supplies, and for home nursing. It should be kept in mind that this plan contemplates rendering service only for acute or emergency conditions.

These funds are distributed on a monthly basis. Bills for services rendered by physicians, dentists, hospitals, druggists and nurses are submitted to the central office of each Corporation. The charges are made

on the basis of a special schedule of fees that have been agreed upon in an understanding worked out by the Inter-Allied Professional Council of South Dakota and the respective State Medical, State Dental, State Hospital and State Pharmaceutical Associations in North Dakota.

In North Dakota the funds will be distributed as follows:

For Physicians	- 51%
For Hospitalization	- 37%
For Dentists	- 8%
For drugs and medical supplies	- 4%

In South Dakota the distribution differs slightly, as follows:

For Physicians	- 51%
For Hospitalization	- 30%
For Dentists	- 15%
For drugs and medical supplies	- 3%
For nursing care (home)	- 1%

Each farm family that participates in this plan is given an identification card upon which is listed all the dependent members of the family who are entitled to medical care under this plan. The family has the free choice of any physician licensed to practice medicine in the State.

At the end of each month all physicians, dentists, hospitals and pharmacists who have rendered services to participants in this plan will submit their bills before the 5th of the following month to the State office of the North Dakota Farmers Mutual Aid Corporation at Bismarck, or the South Dakota Farmers Aid Corporation at Huron. The bills will then be reviewed and totaled. If the total amount of these bills is less than the amount set aside for that period, all bills will be paid in full. If the total amount of the bills is in excess of the amount of money set aside for that period, each bill will be proportionately pro rated. Previous experience with similar plans in the Dakotas has proven mutually satisfactory.

In the community projects, there is a somewhat different problem. These colonies vary in size, some having as many as 250 families. In general, they are agricultural communities. When these projects are located in inaccessible areas, the problem of medical care for the homesteaders is often an acute one. In some instances a local physician has been employed on a part-time basis, and occasionally it has been found necessary to employ a physician who gives his entire time to the project. Whenever possible, the services of all nearby physicians are utilized, rather than importing a physician and employing him full-time.

The financial report given below is the August, 1938, report of a health association on one of the Projects of the Farm Security Administration. The program, which was initiated on March 1, 1938, is administered by the families themselves. All nearby physicians participate in the program, which is confined to general practitioner care. The annual membership dues are $18 per family.

Annual Budget

141 family members @ $18.00		$2,538.00
Planned expenditures:		
Administrative expenses - 5%	$126.90	
For physicians' services, $200.92 per month	2,411.10	
		$2,538.00

Financial Statement

Receipts March 1 to August 31, 1938 . . .	$2,494.50	
Dues Payable	43.50	
		$2,538.00
Total expenditures March 1 to July 31, 1938		$1,057.85

August expenditures:

	Bills	Paid	
Dr. A	73.50	68.47	
Dr. B.	61.00	57.67	
Dr. C.	53.00	49.27	
Dr. D.	27.00	25.51	
	$214.50	$200.92	- 93-3/4%
Salary of Treasurer	5.00		- $205.92

In several communities the homesteaders have organized voluntary beneficial associations which serve as the agencies through which are worked out special agreements with physicians and hospitals. In some instances the families pay regular membership dues in cash, and themselves carry the full financial burden of the medical care program.

In certain other projects the Farm Security Administration loans money to the homesteaders for this purpose, and these loans are later repaid when the crops are sold. A wide variety of arrangements for medical care is evident in these community projects.

Aside from placing public health nurses in a number of the projects, the Farm Security Administration is avoiding subsidizing medical care programs whenever possible. In many projects the families carry the whole load themselves and in most of the others the program represents a combination of subsidy and voluntary support from those families who wish to avail themselves of extra services not covered by the subsidy.

There has not been sufficient experience with these various plans to perfect them. Adjustments and changes will be necessary. It is not felt that these programs are a final answer to all the problems of medical care in rural areas; but it is felt that they are worthwhile examples of methods which may be used in approaching these problems.

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November 1, 1938